GURAGEZONECHILDSURVIVALPROJECT

MIDTERMEVALUATIONREPORT

AFRICARE/ETHIOPIA
OCTOBER 1996

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MIDTERM EVALUATION OF
GURAGE ZONE CHILD SURVIVAL PROJECT
AFRICARE/ETHIOPIA

Acronyms

F. Training Activities
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H. Project Expenditures

GURAGE ZONE CHILD SURVIVAL PROJECT MIDTERM EVALUATION
LIST OF ACRONYMS

AIDS . . . . . *Acquired Immune-Deficiency Syndrome*
BCG . . . . . **Tuberculosis** *Vaccine*
CBD . . . . . *Community Based Distribution of Contraceptives*
CDD . . . . . *Control of Diarrhea1 Disease*
CHA . . . . . *Community Health Assistant*
CRS . . . . . *Catholic Relief Services*
CS . . . . . *Child Survival*
HS . . . . . *Government Health Center*
DIP . . . . . *Detailed Implementation Plan*
DPT . . . . . *Diphtheria/Pertussis/Tetanus Vaccine*
EPI . . . . . *Expanded Program on Immunization*
GCSP . . . . . *Gurage Zone Child Survival Project*
HAF . . . . . *Home Available Fluids*
HIS . . . . . *Health Information System*
HIV . . . . . *Human Immuno-deficiency Virus*
IEC . . . . . *Information, Education, Communication*
IGA . . . . . *Income Generating Activities*
KPC . . . . . *Knowledge, Practice and Coverage*
MCH . . . . . *Maternal Child Health*
MOH . . . . . *Ministry of Health*
NGO . . . . . *Non Governmental Organization*
PHC . . . . . *Primary Health Care*
RHO . . . . . *Regional Health Office*
STD . . . . . *Sexually Transmitted Disease*
TBA . . . . . *Traditional Birth Attendant*
TOT . . . . . *Training of Trainers*
TT . . . . . *Tetanus Toxoid*
USAID . . . . . *United States Agency for International Development*
WHO . . . . . *Woreda Health Office*
WRA . . . . . *Women of Reproductive Age*
ZHO . . . . . *Women of Reproductive Age*

I. INTRODUCTION

A. Background

1. Gurage Child Survival Project

The Gurage Zone Child Survival Project (GCSP) (Project No. 24-14-4301)of Africare/Burkina Faso was approved in October 1994 as a USAID Cooperative Agreement No. FAO-0550-A-00-409-00 under the FVA/PVC Child Survival Support Program. It is a three year project located in two rural districts (woredas) of the Gurage Zone, Ethiopia (see map in Annex XXX).

In collaboration with the Gurage Zonal Health Department and the Southern Peoples' Health Bureau, two districts, Gumer Woreda and (part of) Silte Woreda, were targeted as priority areas to implement a child survival program beginning in the first and second year of activities, respectively. Africare proposed to intervene in 66 Peasant Associations (PAs), 61 within Gumer Woreda and 5 within Silte Woreda, reaching an estimated population of 284,280 of whom approximately 22 % are women of reproductive age; 18 % are children under five; and 4% are infants.

2. Project Goal

The project goal is to reduce child/maternal morbidity and mortality in the intervention areas by:

- strengthening the technical, management, and outreach capabilities of the Zonal Health Department's (ZHD) primary health care (PHC) program through training and material support,
- increasing community health mobilization capacity through strengthening or creation of Peasant Association Health Committees and training of community health workers, and establishing self-help water supply, sanitation and home gardening sub-projects.

The Project concentrates on capacity building in the area of prevention while providing assistance to improve curative services. Training to health staff, emphasizing resource constraints and sustainability, aims to strengthen local health infrastructure. Training of trainers and technical training prepared MOH zonal and woreda personnel to train and supervise community health workers (CHAs and TBAs.)

Emphasis is also placed on developing local health committees and educating local authorities about the importance of PHC in development. The Project should serve as a model for other areas throughout the country.

3. Project Interventions

The specific Gurage CS Project interventions include:

- Promotion of immunization through strengthening of the MOH EPI system, and training of community health workers (CHWs) to carry out health education and community mobilization.

- Control of Diarrheal Disease (CDD) through health education by HAs and CHWs emphasizing prevention and appropriate dietary management of diarrhea.

- Maternal Health/Family Planning. Improved maternal health through training of traditional birth attendants to improve their skills in delivery and referral. Provision of education on available child spacing methods to HAs and CHWs.

- Nutrition/Growth Monitoring and Promotion, Improved child feeding practices as a result of establishment of mechanisms for regular growth monitoring, promotion and follow-up by CHWs and HAs.

The Detailed Implementation Plan was submitted in March 1995, and the project agreement was signed with the Government of Ethiopia in March 1995. The project end date for the GCSP is September 30, 1997.

4. Project Location

The project was planned to operate in two rural woredas of the Gurage Zone ***(see Annex XX)*** which consists of 11 woredas and an estimated total population of 1.8 million. The two target woredas were **Gumer,** which has a population of 276,000 and a land area of 716 square km, and **Silte,** with a population estimated at 276,630 and an area of 680 sq km. Gumer and Silte were chosen by the Head of the Gurage Zonal Health Department because they are poorly served by MOH and NGOs, have alarmingly bad health indicators, and have plans in place or already in effect to provide PHC services to their respective populations.

5. Initial Health Indicators

The project design team in 1993 reported the following health situation:

* In a 1993 UNICEF Report, Ethiopia is listed as having the world's seventh highest under-5 child mortality rate (212 per 1000 live births), and the world's lowest level of measles immunization (17 %).
* Contributing to the high rate of child mortality is a high rate of malnutrition: figures show that 7.6% of children under five were found to have extreme (third degree) malnutrition, measured by weight-for-age below 60% of standards.
* Lack of proper antenatal and delivery care, with over 98% of births attended by untrained TBAs, contribute to an estimated maternal mortality rate of 600 to 1000 per 100,000 births.
- Less than 1% of the Gumer population has access to clean water.
- While signs of xerophthalmia have been observed in young children, actual figures on vitamin A deficiency are not available. Vitamin A-rich foods, with the exception of eggs, are not generally available, and the price of an egg is beyond the means of many mothers.

- Approximately 25 % of women visiting Gumer's health stations show clinical signs of anemia.
- While no lab facilities exist to check for HIV, 780 cases of other STDs (gonorrhea being the most common) were diagnosed in Gumer Woreda in 1992.

The baseline survey for the GCSP was carried out in November/December 1994 using a standardized Child Survival Knowledge, Practice and Coverage (KPC) survey developed by the PVO Child Survival Support Project (CSSP) at Johns Hopkins University. The survey uses the World Health Organization 30-cluster sample survey methodology, and includes basic questions regarding maternal and child health care and nutrition, breastfeeding and weaning practices, diarrheal disease control, immunization, and AIDS prevention. Results from the baseline survey are found in the respective sections of part II C, **Interventions.**

B. Evaluation Methodology

1. Dates and Team

The midterm evaluation was carried out from October 2-22, 1996, by a team led by an independent health consultant, and made up of representatives from Africare/Washington, Africare/Addis Ababa, and Africare/Welkite, as well as staff from the Zonal and Woreda Health Offices and Woreda Health Stations of the Ministry of Health. (See Appendix A for a complete list of team members.)

2. Goal and Approach

The goal of the midterm evaluation was to document project activities, and to study the effectiveness of the selected intervention strategies and their sustainability. The evaluation team used a participatory approach, working together to develop the questions for the evaluation within the USAID guidelines, and according to their specific programmatic interests and information needs. (See the program and schedule attached in Appendix D.)

The team used the following framework to conceptualize project implementation and evaluation: Inputs- > Outputs- > Outcomes- > Impact, as seen in the following table of examples.

INPUTS	OUTPUTS	OUTCOMES	IMPACT
Training for Community Health Workers	Trained CHWs	Better community access and use of preventive and curative care	Better health

Transport and fuel for EPI outreach	Increased EPI outreach activities	Increased access to EPI, higher EPI coverage	Decreased morbidity and mortality from vaccine-preventable diseases
Growth monitoring supplies and training	Growth monitoring sessions	Identification and intervention for growth-faltering children	Decreased morbidity and mortality from malnutrition

Because this was a mid-term evaluation, the process, rather than the results, was the focus. It seemed more important to the team to assess whether the inputs had occurred as planned, and what was the quality of these inputs and outputs. The evaluation would still place some emphasis on whether the outputs seemed to be leading to the desired outcomes.

This approach would allow us to see if what the project was doing was on the right track, and to make any necessary course corrections while there was still time to improve effectiveness of project activities. Outcomes and impact would be the focus of the final evaluation.

3. Methodology

The team gathered quantitative and qualitative data from project reports as well as from individual interviews and group discussions with project and MOH staff concerning: training and continuing education, accomplishments and appropriateness of project activities, project management and administration, lessons learned, and sustainability.

In addition, the evaluation team designed and carried out a qualitative and quantitative field survey in 8 of the 14 accessible Peasant Associations (PAs).

Only 14 out of the 39 project PAs were accessible by car at the time of the evaluation, due to extremely poor road conditions following the rainy season. It was felt by the MOH and project staff that many of the inaccessible PAs are fairly comparable to those visited, since the CHAs and TBAs in these PAs are still able to access their health station and thus are supervised and supplied by their respective health assistants in a manner comparable to those accessible by the team.

In total, interviews and observations were carried out in 8 out of 39 Project zone PAs, 4 of the 5 Health Stations, as well as in the Woreda capital, Arekit, and the Zonal capital, Welkite. Methods used to evaluate the impact of the project training and education activities on health knowledge, skills and behavior of CHAs, TBAs, Health Assistants, mothers, and Health Committee members included:

*service statistic and record reviews,
*supply and materials checklists,

*standardized interview questions,
*open ended discussions,
*focus group discussions,
*observation of curative consultations and EPI outreach activities
*observation checklists for growth promotion and health education activities

The midterm evaluation discussions and observations particularly focused on the level of skills and initiative among the community health assistants and trained traditional birth attendants, their relationship with their supervising health station, and the potential for sustainability of health activities initiated under the child survival project. (See Appendix I for copies of the data collection instruments.)

Feedback from the evaluation was given to Woreda, Zonal, and Regional health and development authorities in Awassa, and other NGOs operating in the same region (e.g. BASICS/Awassa, GOAL and CRS), as well as to Africare/Addis Ababa and USAID/Addis Ababa.

Il. PROJECT ACCOMPLISHMENTS

A. Overall Achievements

	YEAR ONE		YEAR TWO		YEAR THREE
PROJECT COVERAGE	Planned Total	Actual Total	Planned Total	Actual Total	Planned Total
Number PAs involved	20	13	40	39	61
Total Population in covered PAs	90,520	52,782	186,400	180,185	291,196
WRA in covered PAs	19,914	11,612	41,008	39,841	64,063
Children < 5 years in covered PAs	13,578	7,917	27,960	27,028	43,679
Number CHAs trained	20	12	40	39	61
Number TBAs trained	20	9	40	31	61
Number Health Posts opened	20	12	40	39	61
Number of PAs with census	20	13	40	13	61

The project has carried out the following activities:

TRAINING AND SUPERVISION
1 TOT for Zonal and Woreda health staff (2 days)
1 training for census (1 day)
2 sets of training sessions by ZHO, WHO and Africare staff for CHAs (3 months training) and TBAs (1 month training)
2 sets of refresher sessions for CHAs and TBAs (1 week)
1 training session for HAs (1 week)
1 refresher session for HAs (1 week)
2 sets of training sessions for Health Committees and PA Chairmen (2 days)
Monthly supervision of HS, frequent supervision of health posts by HS, WHO and Africare staff

SUPPLIES
Supplied two rounds of pharmaceuticals and supplies to health posts
Supplied health kits to trained TBAs
Supplied equipment and supplies to health stations
Supplies fuel and has ordered two motorcycles (currently in customs) for HS EPI outreach
Developed and supplied health education materials-posters, leaflets in four local languages

HIS
Household census in 13 Pas
Developed HIS and supervisory checklists for CHAs and TBAs
Revised HIS with ZHO and WHO
Provided HIS formats to HS and HPs

COLLABORATION
Participation in Regional, Zonal, and Woreda level meetings
Participation in National Disaster Prevention and Preparedness Activities
Participation in NGO umbrella group (CRDA)
Sponsorship of meetings with Woreda Council and PA Health Committee members
Self-help projects: Women's groups formed in 5 PAs for gardening, IGAs.

Further descriptions and results of these activities are found in the sections below.

B. Original Objectives and Design

1. Project Implementation

The project has been operating for 24 out of 36 months, or 2/3 of the life of the project. The project experienced certain delays in implementation due to the change of project technical advisor. The first project advisor, who was hired when the project agreement was signed in March 1995, resigned in May 1995. The current advisor, who joined the project June 22,

1995, has been on maternity leave since August 20, 1996. In addition, the Addis-based Africare Country Representative and the Country Health Sector Advisor both changed during the first 10 months of the project.

During the first year of the Child Survival Project, most of the changes made in the project design stemmed from the DIP review. In addition, the inability of more than 12 PAs to provide material support for building of a health post and remuneration of a CHA led to a scaling down in the first project year from 20 to 13 PAs (9 with CHA and TBA, 3 with CHA only, 1 with TBA only.) The second year, after seeing the benefit of having a health post and trained CHWs in neighboring PAs, many more PAs were interested and willing to provide resources. Thus, by the end of the second year the number of PAs with a health post and trained CHA increased to 39, out of 40 planned in the Gumer Woreda.

In the second year, Africare proposed postponing the inclusion of the 5 Silte woreda PAs that had originally been planned for year 2. This decision was due to the enormous logistical challenges of developing project activities in the Gumer woreda, which alone covers 716 square kilometers and has a population of approximately 280,000. The project staff felt it was better to concentrate on reinforcing the activities already begun, rather than focusing energy on expansion into another Woreda. (The total population of the 5 Silte PAs was around 15,000, with approximately 3,300 WRA and 2250 children under 5.)

The Zonal Health Office agreed that it was reasonable to focus on strengthening Gumer facilities and activities. However, the ZHO stipulated that the decision not to work in the 5 PAs of Silte Woreda was contingent on the use in Gumer Woreda of the resources previously allocated to Silte. The ZHO also proposed that Silte should be included in any extension of the project.

2. Original and Revised Objectives

The following table lists the objectives as they were presented in the original proposal, and then shows the revised objectives and explanation for these changes. The baseline status of certain indicators is found in the interventions sections.

There are several problems with the calculation and measurement of the figures used in the objectives. The original proposal uses a figure of 121,000 WRA in several places, whereas the estimated proportion of WRA (22%) in the approximate woreda population of 290,000 is about 64,000. The figure of 121,000 in the proposal seems to have been calculated based on the total population of Gumer and Silte Woredas, whereas the proposal only included 5 PAs from the Silte woreda.

Other objectives then use a target figure (for knowledge and practice) of 19,500 WRA, which represents about 1/3 of the correct figure of 64,000 WRA. If the true number of WRA was indeed 121,000, a target figure of 19,500 would mean target levels of knowledge and practice of 16 % .

The revised objectives also stated that there were an estimated 26,831 children under five, but this number is only half the estimated proportion of under fives (15 %, or about 44,000) in the approximate woreda population of 290,000.

Thus the correct population figures should be 64,000 WRA (one half of what was listed) and 44,000 children under five (double what was listed). In addition to these inconsistencies, the use as a target group of mothers of children under five is problematic since the baseline and final surveys interview mothers of children under age two. Some clarifications were made during the mid-term evaluation, but it is recommended to clarify and establish a finalized list of objectives.

a. CONTROL OF DIARRHEAL DISEASES

Original Objective	Revised Objective
At least 60% of an estimated 121,579 WRAs will be taught by CHAs, TBAs and health staff to properly prepare and administer packaged ORS and/or home mixed SSS	At least 60% of mothers of an estimated 44,000 children under 5 years of age will be able to explain how to prepare and administer SSS or ORT with HAF.
30% of WRA will use ORT to treat their children's diarrhea	At least 60% of mothers of an estimated 44,000 children under five years of age will understand the dietary management of diarrhea and that giving extra fluids and food during and after diarrheal episodes can protect their child's health and life.

It was felt that emphasis should be placed on knowledge of HAF rather ORS and SSS, due to ORS access problems and the greater safety and accessibility of HAF. The ORT use objective was changed to a dietary management of diarrhea knowledge objective according to DIP review suggestions. However, the final KPC will still measure ORT use.

b. IMMUNIZATION

Original Objective	Revised Objective
Each target woreda will have sustainable mechanisms in place to maintain full immunization coverage of 70% or better of all infants O-l 1 months of age) at the end of the project.	To put in place sustainable mechanisms to maintain at least 50% immunization coverage of all infants in the project areas by the end of the project.
At least one-third of the 121,579 WRAs will receive two doses of tetanus toxoid vaccine.	At least one-third of the 64,000 WRAs will receive two doses of tetanus toxoid vaccine.

The EPI coverage figure was decreased from 70 to 50% after DIP review comments suggested this was too ambitious. Africare and MOH staff agreed that creating sustainable systems to achieve more than 50% coverage will probably take more than 3 years, even though high levels have already been achieved with Africare support.

c. NUTRITION/GROWTH PROMOTION

Original Objective	Revised Objective
At least 19,500 WRAs will be made aware of the importance of exclusive breast feeding and appropriate weaning foods, and 80% of these women will breastfeed exclusively for 4-6 months and introduce appropriate weaning foods at the correct age.	Increase from 40% to 70% the percentage of mothers who can list appropriate first foods for infants four to six months.
	Increase from < 15 % to 30% the percentage of mothers who can name at least three energy, vitamin A, and iron-rich foods for children and mothers.

	Increase from 11% to 40% the percentage of mothers who know when to begin giving supplemental foods
Establish sustainable mechanisms to assure that at least 50% of children less than 3 years of age are weighed at least 4 times per year, and that follow-up action is taken if a child fails to gain weight over a three month period.	Establish sustainable mechanisms to assure that at least 30% of children less than 3 years of age are weighed at least 4 times per year, and that follow-up action is taken if a child fails to gain weight over a three month period. *

*This objective was revised during the mid-term evaluation to "Establish sustainable mechanisms to assure that at least 20% of children less than 5 years of age are weighed at least 4 times per year", even though the emphasis is on weighing children under 3 years. This was done because MOH HIS data collection is done for weighing of children under five, and it was considered more important to maintain consistency with the MOH HIS. It is planned that the MOH will change their collection of data to % of children under 3 weighed. At that time, the project will change its objective back to 30% of children under 3.

The original objective included general knowledge and specific practice (exclusive breastfeeding till 4-6 months, and introduction of appropriate weaning foods at the correct age) as well as coverage (growth monitoring.) The DIP review suggested that 50% coverage for growth monitoring was too ambitious, as was the 60% knowledge levels. The DIP review also suggested adopting specific, quantifiable knowledge indicators which are measured in the baseline and final surveys. This suggestion was adopted, but the CSP felt it could attain the 60% knowledge levels. It is hoped that the project retains the exclusive breastfeeding and weaning practice objectives, and that their omission in the first annual report was an error. In addition, clarification is needed that the mothers mentioned are mothers of children under two.

d. MATERNAL CARE AND FAMILY PLANNING

Original Objective	Revised Objective

At least one-third of all home deliveries (none currently assisted by trained attendants) will be assisted by a trained birth attendant.	At least **35%** of births will be assisted by trained personnel, up from 5.3%
At least 19,500 WRAs will be made aware of modem child spacing methods, as well as the significance and means of HIV transmission and prevention, and the percentage of contraceptive acceptors will increase from an estimated 1% to **5%.**	At least 5 % (up from 1%) of women of reproductive age will use modem birth spacing methods.

It was felt that attendance of all births by any category of trained birth attendants would be easier to measure that attendance of home births by trained TBAs. HIV was removed as one of the GCSP interventions.

e. CAPACITY-BUILDING AND DEVELOPMENT

Original Objective	Revised Objective
Each target woreda will have strengthened management systems and outreach capabilities in place for the distribution of essential drugs.	Capacity building of health institutions including facilities of zonal and woreda health departments and health stations.
Support nine self-help projects in the provision of clean water supplies, sanitation facilities, and home gardens. Provide health education relevant to these activities,	Support at least 5 self-help projects for the provision of clean water supplies, sanitation facilities, and home gardens.

These objectives have not yet been clearly quantified, although the number of self-help projects (to be carried out with match funding) has been dropped from nine to five.

C. Project Inputs and Outputs by Intervention, Compared to Objectives

For a detailed description of training provided by the project, please see section V-D, Human Resources for Child Survival, For detailed lists of supplies provided, please see section V-E, Supplies and Material for Local Staff.

1. Control of Diarrhea1 Diseases

a. PLANNED V. ACTUAL INPUTS, AND OUTPUTS

PLANNED/ACTUAL INPUTS	OUTPUTS

Training of CHAs and **TBAs- done, plus refresher training**	39 knowledgeable CHAs and 31 knowledgeable **TBAs,** who do health ed and rehydration. CHAs showed extremely good knowledge of preventio diagnosis, assessment and treatment of dehydration, including manageme available fluids, and increased feeding. TBAs knew about diarrhea preve rehydration.
Training of HAs- **done, plus refresher training**	10 better-trained HAs. Not clear what changed knowledge, activities or prescription for diarrhea seemed fairly universal, but other aspects of ap treatment of diarrheal diseases still seemed relatively poor.
Training of PA chairmen, Health Committee members, and animators- **done**	Interest and knowledge by community leaders. Comments during focus g showed awareness of the importance of, and demand for, clean water. T stated that the incidence of diarrhea had dropped due to changed behavio been generalized community support for latrine building. The animators expected to do some health education but their activities were limited to due to lack of interest and role for them.
Provide ORS and ORT demonstration materials for **HS/HP- done**	Facilitation of materials donation from MOH. Health Stations and Healt comers with 1 liter measures and stocks of ORS. Most health workers pr However, some ORT comers seemed under- or unused. The 1 liter meas MOH were not twinned with locally-available containers to provide horn
ORT education and demonstrations by CHAs and **TBAs- on-going**	CHAs and mothers report ORT education and demonstration during HP home visits and during HP consultations for diarrhea. CHAs refer severe interviewed for evaluation reported seeing a case.
Promotion of environmental and personal hygiene by CHAs and **TBAs- on-going**	Mothers mentioned latrines and environmental hygiene as among the mo they had gained from the **CHWs.** Six out of seven HP visited had a latri latrines, although none had facilities for handwashing. Most CHAs repor construction of about 20 latrines in their PA.
Not planned: Development of posters (with MOH) on sanitation, dehydration and breastfeeding in four local languages.	Posters prominently displayed in health posts and stations. Almost all the groups had seen the posters and knew the messages on each one. Some that the messages or images were not very clear. In addition, some HP h local languages that were not those understood in their catchment area.

b. CURRENT STATUS COMPARED TO ORIGINAL STATUS AND FINAL OBJECTIVE

Original Status	Objective	Current Status

In baseline survey, 16 % of mothers reported using ORS, SSS or HAF for diarrhea. Knowledge of SSS/ORS/HAF not measured as such.	At least 60% of mothers of an estimated 44,000 children under 5 years of age will be able to explain how to prepare and administer SSS or ORT with HAF.	Women's knowledge of causes, and management of diarrhea see mentioned by most CHAs, moth leaders that they believed that th had dropped.
Baseline showed that 10% of mothers were aware of some method of dietary management during a diarrheal episode, and 35 % knew of dietary management after diarrhea.	At least 60% of mothers of an estimated 44,000 children under five years of age will understand the dietary management of diarrhea and that giving extra fluids and food during and after diarrheal episodes can protect their child's health and life.	As above. Woreda health statisti what they call CDD coverage- y figures were both 2.5 % , meanin 2.5 % of the estimated diarrheal However, use of HAF seems to according to mothers' comments

c. COMMENTARY

The project's activities in control of diarrheal diseases have been quite successful. An interesting aspect of the project was the strong and seemingly successful emphasis on sanitation and environmental hygiene. This was the subject most frequently mentioned by the CHAs during the mid-term evaluation as being the most useful or interesting, often specifically mentioning building of pit latrines.

After the CHAs graduation and before they received their drug supply, most of them were very active in community sanitation, helping to build latrines in their neighborhoods. At the time of the census in the first 13 PAs, which took place in the first month of Year 2, one month after the graduation of the first cohort of CHAs, 13.5% of the respondents stated that they were using pit latrines. This finding was discussed during the midterm evaluation to try to assess first if the project staff felt that this figure was accurate. It was estimated to be perhaps double the actual rate of use, due to respondent bias, but it was felt that a rate of 7% use would be possible due to the extremely intensive sanitation activities in the first month after CHA/TBA graduation.

The evaluation team set out to verify what seemed like high numbers of latrines being built. The evaluation team discussed the matter with the Woreda Sanitation Officer, who last year won the zonal prize for best performance. He confirmed that interest and participation in building and using latrines was very high. The team also visited several latrines. The villagers seem to be building very simple pit latrines out of locally available materials, usually wood or stones laid across a hole with a brush surround. Monthly reports also report construction of numerous latrines.

2. **Immunization**

a. PLANNED V. ACTUAL INPUTS, AND OUTPUTS

PLANNED/ACTUAL INPUTS	OUTPUTS
Training of CHAs and **TBAs- done, plus refresher training**	39 trained CHAs and 31 trained TBAs who educate mothers about EPI, who assist in mobilization for and implementation of EPI outreach, and who carry out defaulter followup during home visits.
Training for HAs- **done, plus refresher training**	10 better trained HAs. Static and outreach EPI activities seem good quality.
Training for Health Committee, PA chairmen, and animators- **done**	PA chairmen and HC members were very aware of importance of immunization, and reported increased use of EPI services. Some CHAs are working with village elders to increase defaulter compliance.
Increased outreach sites- **done**	Increased number of outreach sites, and better quality outreach services. CHAs observed were extremely conscientious in counseling mothers about possible side effects and when to return.
Increase the number of health posts- **done**	39 health posts established out of 40 planned.
Provide transportation facilities- in **process** Horses and saddles provided to all five health centers. 30 l/month fuel provided for Bole HS ' s motorcycle for outreach activities.	Increased community access to vaccination services through increased outreach. Bach station uses their horse for EPI outreach. The two motorcycles purchased by the project are still stuck in customs, but should be out soon. They will be for Mugo health station and the Arekit Woreda Health Office, which will share with the Arekit Health Station.
Install HIS- **done.**	HIS was streamlined, and immunization cards were printed for women and children. Each health station and the Woreda Health Office were given 2 registration books. Every health station visited had EPI figures posted on their wall.
Not planned: Loudspeakers were procured for each health station and for the Woreda Health Office.	Loudspeakers used for community mobilization and notification of EPI and growth monitoring outreach sessions.

Not planned: Posters about immunization for health posts and health stations	Posters displayed in all HS and HPs. The most frequently mentioned change in the villages due to the CHAs was increased knowledge and use of EPI services. Women's awareness and knowledge of immunization seemed extremely high.

b. CURRENT STATUS COMPARED TO ORIGINAL STATUS AND FINAL OBJECTIVE

Baseline Status	Objective	Current Status
Baseline survey in Nov. 1994: BCG 30% DPT3 19% Measles 23% Woreda service statistics just after project start-up Sept. 1995 in 12-23 month olds: BCG 63% DPT3 54% Measles 38%	To put in place sustainable mechanisms to maintain at least 50% immunization coverage of all infants in the project areas by the end of the project.	Note: Even if the denominator used in HIS is incorre denominator is being used to compare figures from la whether the actual numbers are slightly higher or low Woreda service statistics for Sept. 1996 show: BCG 81% DPT3 74% Measles 53%
Baseline survey in Nov. 1994: only 7% of women had documented TT2. Woreda service stats Sept. 1995: TT2, non-pregnant women: 10% TT2, pregnant women: 18%	At least one-third of the 64,000 WRA will receive two doses of tetanus toxoid vaccine.	Women in focus group discussions seemed very awar Many women whose children were weighed during th maternal health cards with TT2. Woreda service statistics for Sept. 1996 show: TT2, non-pregnant women: 9% TT2, pregnant women: 38%

c. COMMENTARY

Probably the most spectacular gains of the project have been in the area of immunization. The MOH and the project have put a great deal of effort into EPI activities in order to raise these figures, as seen in the service statistics and through community comments.

Each health station visited had adequate stocks of vaccines, a functioning and complete cold chain including cold boxes, up-to-date temperature charts on the refrigerators, and a supply of syringes, although some had reusable syringes in limited enough supply that they considered the supply inadequate since if a large number of children came for immunization, they would have to stop and sterilize the syringes part-way through the session.

Transport is an ongoing challenge- Zizencho's motorcycle, provided by UNICEF, no longer functions, even after Africare tried to get it repaired. The horses provided for outreach, although not as fast or capacious as motorcycles, are a great deal more sustainable, and are not stuck in customs.

The midterm evaluation team paid close attention to the EPI HIS, to verify the validity of the service statistics, and observed several EPI sessions to assess them. A comparison was made between original tally sheets, EPI registers, and monthly reports to the Woreda Health Office. Some slight discrepancies between the different records seemed basically due to math errors.

The evaluation team observed routine static as well as outreach EPI activities to assess quality of immunization services being provided. EPI services in static clinics seemed to be available at all times. The techniques seemed adequate. A weakness is that because of the very high rates of home delivery, children's first contact with the health care system is often at 6 weeks, so that they receive their BCG late.

3. Growth Promotion and Nutrition

a. PLANNED V. ACTUAL INPUTS, AND OUTPUTS

PLANNED/ACTUAL INPUTS	OUTPUTS
Training and refresher courses for CHAs and **TBAs- done**	39 CHAs and 31 TBAs trained in nutrition and growth monitoring (GM). Most CHAs observed were able to correctly plot and analyze weights on the growth chart. Many said that they weigh children who come for curative care, especially those presenting with diarrhea. A few CHAs do GM during house to house visits.
Training for HAs- **done**	10 better-trained HAs. Most HAs observed were able to correctly plot and analyze weights on the growth chart, whereas one HA was not able to do so correctly.

Training for PA and Health Committee Chairmen- **done**	Discussions with the PA and Health Committee Chairmen showed that they were aware of the purpose of GM, but they were not particularly committed to a community solution to malnutrition, other than obtaining food relief as being given in neighboring Woredas, e.g. by CRS.
Provide scales- **done** Detect0 scales given to the trained TBAs. Scales also provided to most HP/HS.	GM is done at HPs during EPI outreach, but most CHAs said they do GM biweekly at the HP. TBAs weigh newborns and refer those under 2500 grams to the HS. Many scales for CHAs were lost in shipment or Customs.
Demonstration and health education on weaning foods- **partially done**	Nutrition education is provided by CHAs and TBAs during home visits, at the HP, and during deliveries. Nutrition demonstrations seem lacking.
Not planned Growth monitoring cards were printed and provided to Health Posts and Health Stations	Besides using growth cards, the CHAs and clinic staff also maintain registers of GM. Their figures are reported monthly by CHAs to HS, and monthly from HS to WHO, who includes these figures in the summary report they send to the Zonal Health office (and copy to Africare) .

b. CURRENT STATUS COMPARED TO ORIGINAL STATUS AND FINAL OBJECTIVE

Objective (baseline figures are included)	Current Status
Increase from 40% to 70% the percentage of mothers who can list appropriate first foods for infants four to six months.	No measures made during evaluation, but mothers seem to be receiving nutrition education. However, they cite obstacles to implementation of new knowledge.
Increase from < 15 % to 30 % the percentage of mothers who can name at least three energy, vitamin A, and iron-rich foods for children and mothers.	As above
Increase from 11% to 40% the percentage of mothers who know when to begin giving supplemental foods	As above

Establish sustainable mechanisms to assure that at least 30% of children less than 3 years of age are weighed at least 4 times per year, and that follow-up action is taken if a child fails to gain weight over a three month period. (In baseline, 3% of children had been weighed in the last four months.)	Mothers are very interested in growth monitoring. Many of those met during the evaluation had growth cards for their children. Some women had even requested scales for their own use in their kebele (sector within PA.) HIS figures show an increase from 3.3 % GM coverage in Sep. 95 to 5% in Sep. 96.

c. COMMENTARY

As in many child survival projects, the growth promotion and nutrition component falls short of intended results. However, compared to other child survival projects, this one at least seems to have the potential to make some gains in actually doing growth promotion as opposed to baby weighing. According to Afi-icare staff, the MOH goal is to weigh EPI-eligible children (those under age two) once a month, although the HIS has not yet been changed to reflect this.

Health worker training focused on identifying growth failure early enough so that appropriate household management can be realistically initiated. The project defined the inadequate growth which should result in follow-up action as failure to gain weight over a three month period.

During focus group discussions, mothers discussed the difficulty of implementing some of the nutritional advice they are given. Two of their most frequent suggestions (besides the often-repeated request for food aid) was that grinding mills be provided, perhaps on a rent-to-own basis, and that credit or income generating schemes be instituted so that women could have more time to prepare the special foods, especially weaning foods, they were learning about, and so that they could purchase some of the more nutritious foods which they do not ordinarily purchase due to their high cost. Another obstacle mentioned by women to making use of the nutritional education they had received was the local unavailability of “locally available” foods, noting the long distances to markets where fruits and vegetables were sold.

A major weakness was not health worker ability to counsel mothers, but rather their failure to do so. A small group of CHAs and Health Assistants seemed to have misunderstood which line stood for which weight, such that all weights were being plotted one kilo above the actual weight (e.g. one CHA plotted a weight of 7 kilos on the 8 kilo line, which is the same place the Health Station had plotted it for the same child during a growth monitoring session the previous week.) This systematic error probably contributes significantly to the absence of severe malnutrition being reported in these catchment areas. Another weakness observed almost uniformly was the failure to ask the mother to repeat the instructions she had been given, and failure to tell the mother when to come back for the next weighing. Health personnel were given feedback on these points, which will be followed up closely during subsequent supervisions and refresher trainings.

Having seen that growth monitoring seems to be going on, and it seems at least possible that it be carried out in a reasonable fashion, the question arises of what happens when the growth monitoring identifies a child who, in spite of nutritional promotion, fails to grow adequately.

Several CHAs interviewed mentioned having found severely malnourished children (< 60% weight for age) and referring them to Attat hospital, which has a nutritional rehabilitation program. One CHA reported that of two referred to Attat, both went and came home cured. Subsequent followup showed one child maintaining adequate weight, and the second one faltering again. The CHA told the family that this was a serious problem, and insisted that they take action.

4. Maternal Care and Family Planning

a. PLANNED V. ACTUAL INPUTS, AND OUTPUTS

PLANNED/ACTUAL INPUTS	OUTPUTS
Training and refresher courses for 39 CHAs and 31 TBAs- **done**	39 trained CHAs and 31 trained TBAs who educate mothers about safe motherhood, who assist uncomplicated deliveries and provide antenatal care, and who counsel on FP.
Training for HAs- **done**	10 better trained HAs who are providing ANC and FP as well as delivery services.
Training for PA and Health Committee Chairmen- **done**	PA chairmen and HC members were very aware of the importance of safe motherhood and the relationship of FP and land tenure issues.
Provision of TBA kits to trained TBAs- **done**	Trained TBAs received kits which they use during deliveries. They are happy with kits, but note lack of gloves.
Increase pre-natal outreach services- **ongoing**	Each health post has established a private space with a bed for women to use during deliveries. This is also used for ante-natal care by TBAs or by HS personnel, who have started providing ANC during EPI outreach. Delivery tables were provided to HSs.
Health education about safe motherhood and FP- **ongoing**	CHAs and TBAs provide health education about safe motherhood and FP.

b. CURRENT STATUS COMPARED TO ORIGINAL STATUS AND FINAL OBJECTIVE

Objective	Current Status
At least 35% of births will be assisted by trained personnel, up from 5.3%.	The HIS showed an increase in the percentage of births in the Woreda being assisted from 1% in Sep. 95 to 2% in Sep. 96, and increase in ANC coverage from 16 % to 36%. Evaluation showed a range of births assisted by trained TBAs since their training between 0 and 40. The HS receive an unknown number of referrals from HPs.
At least 5% (up from 1%) of women of reproductive age will use modem birth spacing methods.	The HIS showed an increase in FP from .86% in Sep. 95 to 1% in Sep. 96. The three Health Stations reported about 150 FP users each, (mostly pills) with the fourth numbering about 30 users. If the Kutere HS has the average number of users (120) reported, that would give a very rough CPR of 1% for the Woreda (600 users out of 60,000 WRA) based on HS users alone, not including any other FP sources.

c. COMMENTARY

The evaluation team witnessed two women from different kebeles being brought to the same health post at the same time, one for a retained placenta and one for a high-risk delivery. Both were appropriately referred to the Health Station, and both women were actually taken to the health station by their families, one on a stretcher, and the other in a basket carried on poles. The team saw both women at the health station, where they seemed to be appropriately treated.

One CHA stated that men are very willing to use FP, but the women refuse, both because they want many children, and because they fear sterility. Other CHAs mentioned that cultural value placed on large families, religion and absentee husbands were major obstacles to FP.

Several CHAs mentioned that they had clients (one CHA said he had 50) who were interested in using the pill, but they found it difficult to make the long trip to the health station to be examined and to obtain the pills.

It was arranged between two CHAs and the Health Assistants from the nearby health stations, who were participating in the evaluation team, that these women would be screened during the next EPI visits to the health posts. Two other CHAs and TBAs arranged with their supervising

health assistant that they would be able to resupply women with pills after an initial screening at the health station.

The Woreda and Zonal Health staff were very supportive of these initiatives, which are seen as pilot activities, since CBD of pills by non-medical personnel is not part of MOH policy.

Despite these innovative approaches to increasing access to FP services, many obstacles remain to increasing contraceptive prevalence. It will certainly remain low until contraceptives are readily available at local level. The upcoming launch of PSI/DKT's social marketing of oral contraceptives may increase the prevalence levels, but health service providers' attitudes are one of the first things that seem to need to be addressed before looking at changing women's and men's attitudes to FP use.

d. CAPACITY BUILDING AND DEVELOPMENT

Revised Objective	Results
Capacity building of health institutions including facilities of zonal and woreda health departments and health stations.	TOT has been done for 10 Zonal and Woreda Health staff. HAs have received training and refresher courses in child survival and HIS. Training in management for HAs had been planned for next month, but the poor showing on diagnosis and treatment has changed training priorities. Project staff have worked with ZHO and WHO on training, supervision, HIS, IEC materials development, and participatory evaluation.
Support at least 5 self-help projects for the provision of clean water supplies, sanitation facilities, and home gardens.	The Project is working with women's groups in 5 PAs to prepare for IGAs. However, the match funding is still being sought. One PA Health Committee had an interesting difference from the regular request for food aid. The younger members requested food aid, but the older members said that they did not want that, but what they did want is technical assistance, perhaps from the Ministry of Agriculture, so they can increase productivity and the variety of vegetables that they grow. Several other Pas requested assistance in this area as well. Dry season agriculture is currently not a possibility, due to the extreme shortage of available water at the time. Water funds are the highest priority and the highest cost.

III. EFFECTIVENESS

A. Support to MOH

This project is exceptional in its level of commitment to supporting rather than replacing MOH services, training and supervision. In addition, an enormous effort has gone into the development of community ownership and support for community health activities. The

amount of effort put into supporting MOH systems and trying to create a sustainable cadre of community health workers has thus not been spent in actual service provision or health education by project staff.

This means that less immediate impact occurs than if a group of animators were hired to carry out health education and do training and supervision of CHWs. However, this approach of reinforcement of existing structures seems much more effective in the long run than focusing on short term results. The first year was primarily devoted to meeting information needs, reporting requirements, development of the DIP, and logistics and management support. Personnel changes also decreased the ability of the project to begin activities rapidly, as discussed below.

Another problem noted was the recruitment of MOH staff as Africare employees. This creates a dilemma- usually the most active and qualified health professionals are those that are already working, and most of these are working for the MOH, which means taking away badly needed human resources from the MOH, and skimming the "cream of the crop".

It is for several reasons, however, that this practice is less problematic than it may initially seem. The first reason is that some MOH staff state that, due to lack of resources within the MOH system, they have more impact when they can leverage the resources available to them as NGO staff. Others complain that due to internal political conflicts, their effectiveness is limited in the MOH system.

Another reason is that MOH staff, when they go to work for an NGO, often receive intensified in-service training, and gain valuable management and technical experience. They can return with this knowledge to the MOH when their work with the NGO is finished. Likewise, if they continue to work for other NGOs, they will still be using these skills for improved health care in Ethiopia.

A third reason that this practice is not necessarily harmful to the MOH personnel base is that NGO hiring of outstanding MOH personnel assigns these upwardly mobile professionals to NGO activities, which often target the most disadvantaged. These former MOH personnel thus are being paid by the NGOs to apply their talents to reinforcing local MOH structures through collaborative planning, training, formative supervision, and resource management, rather than being promoted up and away from these rural zones.

B. Training and Education

In addition to taking a very sustainability-oriented approach, the project has also successfully done what few CHW projects manage to do- it has carried out good quality, substantial (90 days for CHAs, 30 days for TBAs) training programs, and then has followed them up with supervision and refresher training, all within an 18 month period. This has resulted in the creation of a corps of very well trained and competent CHWs. CHA and TBA efforts in health

education and promotion seem to have led to increased levels of knowledge and improved health practices among the target populations.

In addition, by involving MOH personnel in the planning, selection and training of CHAs, MOH training capacity has been strengthened, and the CHWs are seen as MOH adjuncts. This is especially important, as MOH policy intends that the MOH will eventually support health posts and CHAs in each PA.

Feedback sessions with the Regional Health Bureau and the Regional DPPC Bureau showed great satisfaction on their parts with the very sustainability-oriented approach taken by the project, although both were very interested in seeing short-term results, e.g. ensuring that EPI rates were high. They stated that they were very pleased with the level of cooperation and collaboration that they have had with Africare.

C. Cost-Effectiveness

The project has been able to create a lean, on-going structure which is providing a great deal of technical assistance, supervision and support to the community for a relatively low recurrent cost. The total monthly expenses (including everything- all local costs, expatriate field and headquarters personnel and benefits, and overhead and other direct costs) for June, July and August 1996 averaged $14,223 a month.

This works out to $0.2 l/month, or $2.55/year per WRA and under five child for the current covered population, or $0.13/month $1.56/year for each WRA and under five child in the Woreda. The total Woreda population will be covered in the third year of the project with small investment expenses in addition to the project running costs cited above.

D. Constraints

Staff Turnover - Several changes in personnel have delayed project implementation and hindered even greater achievements than the project has managed. Catherine Allen, the former Project Advisor was not hired until March, 1995 and then resigned in May, 1995. The second Project Advisor, Hiari Imara, was in place by the end of June, 1995. This change resulted in the delay in hiring and orienting of the Project Manager and of the Accountant/Financial Officer until August, 1995. In the Africare/Ethiopia Office, the previous Country Representative ended his contract in January, 1995, and a new Country Representative took his place. This change resulted in restructuring of the country office and temporary lack of administrative support. The Africare/Ethiopia Health Sector Coordinator, Dr. Gebreselassie, ended his contract in July, 1995 and was replaced by Ato Haile Wubneh in February 1996. Two field coordinators were hired in May 1996, but one was not able to obtain an official release from the MOH, so he stopped work August 3, and has not yet been replaced.

Delay iu initiation of the KPC survey - The KPC was to have been conducted in October, 1994, but it did not actually start until the end of November. As a result, the collection of

data, analysis of baseline findings, the writing of the Baseline Survey report and the development and submission of the Detailed Implementation Plan (DIP) were also slightly behind schedule (six weeks to two months).

Logistical and bureaucratic constraints - Progress was slow in obtaining housing and office space at the project site, Welkite. The housing market in Welkite is very limited and although a house was identified, extensive repairs and modifications were required by the Project Advisor. Similarly, office space for the project was difficult to locate. Initially, the Zonal Health Office offered one of their spare rooms, but in August, 1995 the roof was tom off in a storm. Thus, the CSP had to locate new office space, which was completed at the end of 1995. The new office space has the advantage of being located within the Zonal Health Office compound, which increases ease of collaboration with ZHO officials.

There have been bureaucratic delays with the Ethiopian government, specifically the Relief and Rehabilitation Commission (RIK), now the DPPC, which oversees all NGO activities in Ethiopia. There were difficulties in clearing project supplies (e.g. vehicle, computer etc.), opening the project bank account at the project site, obtaining the CSP Advisor's work permit and residency permit, and clearing HS/HP supplies through customs.

Low community support and irregular payment **for some CHWs.** Some problems are reportedly due to the recent changes in the administrative structure of some Gumer peasant associations (some PAs are being combined from 2 PAs to 1 PAs), and recent elections removed many PA chairmen with whom the MOH and Africare had negotiated commitment to provide financial support for the CHWs. The PA chairmen have been too busy recently with administrative changes and with on-going tasks such as tax collection to focus on collecting CHA salary payments.

In addition to conducting regular supervision and support of CHW and health station activities, the technical field workers will promote the work of the CHWs and regularly meet with PA chairman and community members to improve community support and ensure regular salary payments for CHWs.

Suggested solutions included: closer collaboration between health committees and CHWs to educate and mobilize the community, organization of community meetings in each PA, and recruitment of volunteers to support health programs and CHWs. Bi-weekly health committee meetings at PA level and monthly meetings at the health station level were instituted in several areas. Additionally, a competition was instituted among different PAs, with awards for outstanding PA, CHA and TBA.

Shortage of drugs The evaluation team noted a severe shortage of drugs in the health posts which were to be supplied by Africare. This is seen as a major problem by the PAs, the CHWs, and the mothers. This is partially due to an insufficient supply of drugs in the first phase of health post drug distribution, due to inadequate supply at Epharmacor government depots, and a delay in drug resupply as most drug items were again not in stock. Some of the

second cohort of HPs never received some of the basic drugs on the HP list, since they were apparently not available through the government depots. In addition, the project staff had hesitated to restock until they had collected more of the funds from the sale of HP drugs (about 50-60% of the receipts have been collected.) It was decided during the evaluation to go ahead and obtain an emergency stock of the essential drugs such as paracetamol, chloroquine, mebendazole, aluminum hydroxide, etc. with the currently available revolving fund balance of 5,000 birr until such time as more stocks can be obtained.

Irregular supervision: Although the project has done a reasonable job of supervision, some weaknesses were noted. These seemed due partly to weak supervision by the health stations, as well as a lack of overall planning by the project, and failure by MOH and project staff to pro-actively use the monthly HIS reports to identify potential problems. Other constraints to regular supervision include: lack of transportation for the Zonal and Woreda Health Offices, bad road conditions, long distances, the loss of one project field technical coordinator, and the lack of project advisor presence in Welkite. The one very weak health post visited by the evaluation team was one that had received the most infrequent supervision. It was planned to improve the regularity and targeting of supervision, taking advantage of all available transport to health stations and health posts, and having the project staff spend more days in the field sites.

Inappropriate choice of volunteers: Although the project, together with the MOH, asked the PAs to apply the GOE's selection criteria for CHA and TBA candidates, these were not always correctly applied, nor did were the people chosen as CHAs and TBAs always the most appropriate ones. The evaluation team met two trained "TBAs" who were unmarried girls in their late teens. The project staff as well as the women themselves agreed that they were not appropriate choices for TBAs, since it is culturally unacceptable for an unmarried woman to attend a delivery. Neither of these two had attended deliveries prior to or after their training as TBAs. It was agreed between project staff and ZHO and WHO staff that stricter application of certain selection criteria would help eliminate this problem in future PA trainings. Project and MOH staff began arrangements to identify appropriate replacements and alternate roles for the inappropriate trained TBAs.

Iv. RELEVANCE TO DEVELOPMENT

The activities of the project are extremely relevant to development, particularly since the emphasis is on building community support and capacity for health improvement.

A strong point is that the project is working with the Woreda Council, which is responsible for all development activities in the Woreda. The Woreda Council is trying to create a multisectoral development committee composed of about 25 community leaders in each PA, with subcommittees for health, agriculture, etc. This should increase the impact and integration of community health activities as supported by the project with overall development activities.

The project is also working with women's groups to develop income-generating activities. Some of the proposed activities include group purchase of grain mills, small credits, and gardening.

A weak point of the project is the inability to provide water supplies, which are essential both for improved health, for vegetable gardening, and for freeing women's time for income-generating activities.

Ten years after the severe famines that claimed a million victims, Ethiopia is moving from a relief mentality into a development phase, as seen in the recent change of the name of the important Relief and Rehabilitation Committee to the Disaster Prevention and Preparedness Committee. Within this challenging context, project designs such as this one which emphasize sustainability and strengthening of existing structures are extremely important in creating a development, rather than relief, mentality.

The Project has made significant contributions to development. Target groups are being reached effectively with a sustainable approach.

V. DESIGN **AND IMPLEMENTATION**

A. Design

During this quarter, the CSP determined that the five PAs from the Silte woreda should be removed from the project area. The issue was initially raised in early 1996, after in-depth review of project status reflected the necessity of modifying the project design. Major reasons for the removal of Silte include: majority of staff resources are still needed in Gumer woreda, further Project delays would be caused if staff took the focus off of Gumer and poured time, energy, transportation in Silte now thereby affecting project sustainability, the target area in Silte includes only 5 peasant associations (estimated pop. 15,000) while Gumer population is nearly 300,000. There are several other reasons for this change in project design (See Attach. XX).

CSP staff has met with Dr. Mituku, Head of the Gurage Zone Health Department to discuss this issue. Dr. Mituku was supportive of the justification and will assist Africare in obtaining concurrence from the Regional Health bureau (See Attach. XX same # as above).

Removal of Silte should not have a major impact on Project objectives or outputs. If the Project has a second phase, Silte will be included in future activities.

Other design changes include the changed objectives as described above, and the deletion of the HIS officer position.

B. Management and Use of Data

The CSP has eight project objectives which have been revised as indicated in the above section. The project has two types of data collection systems which track progress toward these objectives. The first is the periodic system, which includes baseline and final knowledge, practice and coverage surveys which all Child Survival Projects are obligated to carry out, as well as the midterm and final evaluations. The second, routine system includes the following data collection tools, which have been adopted or adapted from the MOH HIS, and are used by MOH and project alike.

1. MOH Mother and Child Health Card/Growth Monitoring Card
2. Maternal and Child Tracer Slips (not generally used)
3. MOH Maternal Health Card
4. Monthly EPI Disease Surveillance Form (1 in Amharic for Health Posts, 1 in English for Health Stations, sent in if cases found)
5. Monthly CHA Reporting Form (based on MOH code formats)
6. Quarterly Vital Registration Form (used rarely by CHAs)
7. Quarterly CHA Report Form (used by HS and WHO to compile monthly CHA reports)
8. Monthly Integrated Reporting Form from Health Stations
9. Monthly EPI Report Forms from Health Stations

The health information generated by these two systems is used by HS, WHO, ZHO and project offices for monitoring MOH and project activities and assessing health indicators and objectives. For greater efficiency and sustainability, the project has used the MOH HIS, working with the MOH to adapt the HIS for greater effectiveness at the health post and health station level.

The project seems to have helped develop a relatively complete and well-functioning MOH HIS. The activity reports were detailed, fairly complete, and seemingly accurate. It was easy to obtain information on individual health post and EPI outreach site activities for a given month, and relatively easy to compare these reports to registration books, etc.

During the Health Assistant training exercise, conducted in September, 1995, one of the issues raised during group discussion was the complexity of some of the forms. Several days of the training were devoted to explanation and utilization of HIS instruments.

An HIS consultant was hired to develop the planned household census, the first phase of which was carried out in order to have population-based data similar to the Save the Children household registration approach. However, this was seen to be too cumbersome and expensive to repeat for each further group of PAs, so the population data obtained by the household census in the first 13 PAs is used to generalize about the characteristics of the other PAs in the project zone. This seems a better approach than carrying out the household census in all 61 PAs which would take more time and money than it is worth, and require, because of the logistic demands, more money than was originally budgeted. Vital registration activities are more useful, although they are still in a nascent phase.

During the evaluation, further discussions were conducted with zonal, worcda and health station staff on the effective use of HIS instruments and on possibilities to streamline the forms for improved data collection. The suggestions and comments from this zone should be shared with the regional MOH, to influence possible changes to standard MOH forms at the regional and national level.

Further recommendations include targeting health information collection to project and MOH objectives or adapting objectives to existing data collection, as was done with certain objectives during the midterm evaluation. Other recommendations include development of a system to help target home visits to follow up of EPI and growth monitoring defaulters and identified growth falterers. The HIS also should be used by HS to identify HPs with problems, and by the WHO and project to identify problems in the health stations to focus supervision and training. It was also agreed that the vital registration system was very incomplete, and that this should receive less effort for the present.

Africare is using this innovative project design as a model for new projects in other regions, and applying the lessons learned to ongoing projects.

C. Community Education and Social Promotion

The project focuses almost exclusively on promoting the Ministry of Health and communities' abilities to carry out health promotion/social mobilization and service delivery. There is no direct child survival service provision by CSP staff, and there is a limited amount of provision of supplies and recurrent costs for MOH and community health activities.

The project provides support for MOH EPI, growth monitoring and antenatal care outreach activities, which are done by the health stations at each health post on a monthly basis. In addition, the project has worked with the MOH to train and supervise CHAs and TBAs to carry out health education in their communities. The health education messages provided by the CHWs are those from the MOH curriculum. In addition, the CHWs were trained by teams of MOH and project staff. This ensures consistent messages from MOH and project personnel.

The project developed health posters for distribution to health stations and health posts. There are five different posters about breastfeeding, sanitation, EPI, diarrhea, and growth monitoring. Four were translated into 4 different local languages, and one was translated into two of the local languages. The project staff took pictures in local health stations, feeling that these photos would be more easily understood by the local population. These posters were pretested with selected members of the population. The posters were distributed to the health posts and stations, as well as 1,200 leaflets on child survival subjects.

During the mid-term evaluation, it was found that the staff of health facilities are mixed in their appreciation of these posters. Some liked them, and said the only problem was a shortage of them (although no health post had less than 6 posters). Other health staff stated that the pictures were not clear, and that women did not understand the meaning unless it were

explained and the written messages were read to them. The pretesting does not seem to have ensured maximum clarity and effectiveness of the images and messages. It was observed that the formats of some of the posters lacked clarity, and had too many messages (e.g. two of the posters combine drawings and photos.) Mothers in the focus groups were about evenly divided on the clarity of the images.

Another problem noted, besides the fact that only about 20% of the population is literate in any language, several health posts had received posters with the wrong local language for their area. Arrangements were made to rectify this.

It is recommended to re-evaluate the use of posters as health education materials in this mostly non-literate area, and focus IEC activities on more interactive, traditional and entertaining forms of education and discussion.

The project's approach to community education is through interpersonal communication by CHWs during curative and preventive activities at the health posts, and through home visits. No non-traditional or participatory education activities are being carried out other than discussions with mothers during health education talks, and a few role plays. During the mid-term evaluation, health education talks by CHAs and Has were observed to see their capabilities. (See Annex XX for results.) Feedback was given on how to ensure mothers participate, and that they understand the take home message. In addition, an assessment of nutrition education during growth monitoring was carried out during the midterm evaluation. (See Annex XX for these results.)

The project has assessed the level of learning that has occurred in mothers since the baseline KPC survey through informal discussions and through the mid-term evaluation.

During the midterm, focus groups were held with mothers in seven PAs to ask them about what they have learned, and how they have been able or unable to implement what they have learned. Discussions with PA chairmen and health workers were also held, during which they were asked to assess the level of behavioral change due to the health promotion activities of the CHAs. This was generally stated to be quite significant, by mothers, PA chairmen and health workers themselves.

The major focus of the HIS and the midterm evaluation has been on process, rather than impact, but the final KPC survey will document whether the process, which as measured by process indicators has been moving ahead nicely, has had the expected impact on mothers' knowledge and behavior.

D. Human Resources for Child Survival

Please see the project organigramme in Appendix XX. Africare/Addis staff who spend time on CSP activities include the expatriate Country Representative, the Health Sector Coordinator, and the Administrative/Financial Officer. The Welkite GCSP office includes the expatriate Project Advisor, the Project Manager, one (formerly two) technical Field Supervisors, the project accountant, project driver, and an office helper.

The number of CSP personnel will be adequate once a second technical field supervisor is hired to replace the one that was unable to continue since the MOH would not release him. The project advisor's role in filling project managerial, technical and operational project needs seems to have been compromised by her seeming reluctance to fully install herself in Welkite, due to a range of complaints about the available housing. However, given the existence of adequate hotel facilities in Welkite with electricity, running water, flush toilets, etc. it is difficult to understand why it took almost a year for the project advisor to move to Welkite from Addis Ababa. The project advisor's protracted absences from Welkite have detracted from her effectiveness, and the quality of the project has suffered.

Full-time presence in Welkite and in the Gumer Woreda by the Project Advisor is essential in order for the Project Manager to be more able to carry out coordination with the WHO and increase joint field supervision of health posts. It is also suggested that additional technical assistance be obtained in IEC and use of HIS for project orientation.

The project uses community health assistants who are volunteers only in the sense that they are not paid by Africare. Agreements have been signed by the PA and Health Committee Chairmen as to the amount of remuneration pledged by the PA per month to the CHA and the TBA. This amount ranges from 40 to 150 birr (6 birr/$) per month. It was seen as unrealistic to expect people in this desperately poor area to work as purely volunteers.

The 39 CHAs and 31 TBAs hold health post hours for 20 hours a week on average, and in addition do home visits and see emergency cases outside of the regular Monday-Friday 8-12 health post hours.

Partially, perhaps, because of the lengthy training and thus substantial per diems obtained at the beginning of their involvement, in addition to the supervision and recognition by Africare and MOH staff, as well as the financial incentives provided by the Pas and some members of the community for delivery services, there are apparently only about five or six of the 39 trained CHAs who are no longer active. Of this number, most have gone on to work with various organizations, and only one or two seem to have just returned to their previous occupations.

The CHA and TBA in one very isolated health post seem to have been fairly inactive for the last 6 months. This is due to a number of reasons: change in the PA chairman and subsequent

lack of political support, their Health Station's lack of EPI outreach for the last 6 months, the infrequent supervision by Africare and WHO, and probably most importantly due to the installation of two illegal drug injectors in the village, whose wares are seen as much more valuable than the very limited and mostly exhausted supply of drugs that the CHA has. The CHA maintains records of the approximately six patients he sees per month, and has participated in CHA meetings, but had never mentioned his problems until the evaluation team visited.

Because the health posts report to the Health Station, which then groups the health post statistics and report them to the Woreda Health office, these very low service statistics, which would indicate the need for follow-up, were not picked up by the WHO or Africare. The Health Station should have seen that there was a problem, but the Health Station itself seems to be the weakest one in the zone. This indicates the need for better monitoring and use of service statistics to indicate problem areas.

The training for the CHAs lasts three months, and was carried out by MOH staff, along with Africare staff. Pre and post training assessments were carried out. The training seems to have been of good quality, and the supervision and refresher courses, which were modified to include practical training at the local Catholic hospital and with their community health workers, were apparently very successful in creating a knowledgeable and skilled group of CHAs and TBAs. It is strongly suggested to more actively include health station staff in selection of CHW candidates and to refuse to accept at a training any candidate who is clearly inappropriate, even if this means leaving a PA without a trained TBA until the next round of training.

See tables of training activities and content in Annex X.

E. Supplies and Materials for Local Staff

Materials and supplies essential for each intervention have sometimes been difficult to obtain, although in general the project has succeeded in supplying most items.

DRUGS: A major obstacle to provision of services has been the difficulty of obtaining sufficient supplies of drugs for the health posts. The Woreda, Zonal, and Regional level health offices do not have sufficient stocks to supply their own health stations, much less the health posts. Africare has attempted to purchase drugs directly from Epharmacor (the pharmaceutical parastatal), but there has been no stock available of numerous essential drugs. The first group of health posts received a relatively complete first lot of drugs, but the second group did not receive the complete list of drugs. Mebendazole was originally on the list of drugs for health posts, but it was temporarily deleted from the list by the GOE since it was seen as too expensive.

Africare's difficulty in keeping a stock of basic medications remains one of the greatest weaknesses of the health posts, since the first source of credibility for CHAs is their curative ability, which is lost when they have only a few or no medications available. Arrangements began during the evaluation to obtain an emergency stock of drugs to tide over until more sustainable supply systems are in place.

EQUIPMENT: The project supplied basic materials to each health station and health post (see lists in Annex XX.) However, because some of the scales were lost in shipping, some health posts did not receive scales for both the CHA and the TBA. The health posts seem sufficiently equipped for the limited services they provide.

TRANSPORT: Horses and saddles were provided to each health station. In addition, two motorcycles were purchased for the health stations who did not have functioning motorcycles. These have been stuck in Customs for the last three months, but a series of visits and letters seems to be on the verge of freeing them from bureaucratic snarls. The horses and motorcycles, as well as funds for fuel for existing motorcycles, have been a most important tool to increase EPI outreach and supervision.

A continuing transport obstacle is the shortage of transportation for the Gumer Woreda Health Officer for his supervision of health stations and posts in the Woreda. It has been attempted to maximize coordination between Africare and woreda staff for supervisory visits.

Another concern was that the distance between Welkite and Arekit, the WHO location in the capital of Gumer Woreda, has posed a problem for the timely arrival in the morning of Africare staff to pick up the WHO staff and then go on to health station or health post to be supervised. It can take an hour and a half to two hours to go from Welkite to Arekit, and the accessible health posts and stations that the evaluation team visited, during the dry season can be more than an hour away from Arekit itself.

It was suggested by the WHO that a branch office be installed in Arekit. The reasons which led to the establishment of the CSP office in Welkite still hold- the CSP is supposed to coordinate with the Zonal health office, and the absence of electricity, adequate phone services and most other amenities in Arekit would make it much less feasible to have the project office based there. However, it is recommended that field supervisors and other staff who will be going out on supervisions to spend one to two nights a week in Arekit or Mugo which will put them an hour and a half closer to the health facilities to be visited.

F. Quality

The project baseline survey identified the enormous need for information. Surveys of health workers have identified their training needs. Trainings have included pre and post tests, and

supervisions have shown relatively high output of services. However, there has been less emphasis during supervisions on service quality, although a supervision checklist developed by the project and MOH staff did look at a few aspects of quality.

The mid-term evaluation consultant was asked specifically by USAID/Addis, as well as by the Zonal Health Director, to look at training results. The mid-term evaluation thus focused on the quality of services and information being provided by project-trained HAs and CHWs.

Based on the results observed, the training was good quality, and the knowledge and skills of the CHAs and TBAs seem high in general. Most CHWs seem to be very active and successful in educating their communities, and increasing health promotive behaviors. The weak point in the quality of services is the insufficient drug supply.

The findings of the evaluation team were surprising particularly for the Zonal, Woreda and Health Station staff, many of whom were quite surprised at the depth of knowledge and skills possessed by the CHAs and TBAs. There were a few debatable practices that were learned (e.g. TBAs were trained to encourage mothers to abandon the traditional method of squatting during delivery), but it was noted many times by MOH staff as well as the rest of the team that the CHAs and some TBAs were more knowledgeable and skillful than many Health Assistants.

Unfortunately this says much about the quality of the Health Assistants' interest and motivation to improve their skills. Health stations ranged from model to fairly poor, although many of the health assistants received refresher training under the project. Either old habits are hard to break, the training was insufficient, there is insufficient motivation to change their behavior, or a combination of the three.

Based on these findings, the project plans to hold refresher training for health assistants in diagnosis, treatment of common complaints, and in management of drug supply and clinical services.

G. Supervision and Monitoring

Supervision by project staff seems frequent. All Health stations and health posts (except one) visited reported frequent visits from WHO and certain members of Africare staff. More efforts need to be made to ensure that supervisory visits by Africare staff are used as supervision opportunities by Zonal, Woreda, and health station staff, since transport is such a problem. In addition, Africare should facilitate linkages between ZHO and WHO officials and zonal and woreda level officials of other ministries to promote joint use of supervision transport. The Woreda Council Social Sector official, who is responsible for health activities, expressed interest in participating in occasional health facility supervisions.

A supervisory checklist was developed by the project which looks at administrative, technical and managerial issues. **A** weakness noted, however, is that there was little quality checking of ongoing activities. Again, greater presence in Welkite of the project advisor and more frequent visits to health facilities would help rectify some of the above noted weaknesses.

The five health stations cover an average of 12 PAs each, out of which an average of **8** PAs have CHAs and TBAs who need to be supervised. The HS supervises the CHA/TBA activities through their monthly visits to the PAs for EPI outreach activities, although the frequency of outreach visits is lower during the rainy season. The HS supervision collects service statistics, addresses any problems encountered in the CHA/TBA's work, and provides resupply of certain commodities, as well as other functions. The focus seems to be on administration rather than quality of care, although some on-the-job education is provided.

The Africare field coordinators work in conjunction with the WHO staff to oversee and complement the Health Stations' supervision of the health posts, In addition, some support is provided to the WHO in the supervision of the five health stations, especially by the project manager. Additional supervision of health station activities seems necessary to follow up on the training provided by Africare and the MOH to the health assistants, and to solidify their diagnostic and treatment skills as well as management capacities.

The HIS does a good job of collecting information about ongoing activities by health station catchment area. This information can be very useful to identify problem PAs or health stations and target supervision to problems showing up in the monitoring. However, it is not clear that these results are used fully to that end. The project staff should focus on working with Zonal and Woreda staff to improve use of HIS for decision-making and targeting efforts to improve quality, coverage and sustainability of services.

H. Regional and Headquarters Support

Personnel from the East Africa Regional Office at Africare/Washington headquarters providing support to the GCSP include Mr. Alan Alemian, East Africa Regional Director, Mr. Stephan Solat, Child Survival Program Manager for the Region, Mr. Gabriel Daniel, Headquarters and Field Public Health Specialist. They provided technical support and advice to the project through headquarters-based backstopping as well as through several field supervision visits. Stephan Solat backstops three country health programs- Ethiopia, Eritrea and Nigeria.

I. PVO's Use of Technical Support

The CSP received technical support from the Ethiopian Ministry of Health and Africare/Washington to conduct the baseline survey in November, 1994. Several individuals who provided field technical assistance included: Dr. Geira Baruda and of the Gurage Zonal

Health Department and Dr. Gebreselassie, Former Health Sector Coordinator of Africare/Ethiopia.

A consultant was hired to design, supervise and analyze the household census carried out in the first 13 PAs. In addition, an external consultant led the mid-term evaluation and the resulting formulation and implementation of recommendations.

Technical support in HIS and IEC is desired early in this remaining year of the project. Local IEC expertise is difficult to obtain, so it may be necessary to use external IEC expertise for more effective IEC strategies. The project should also consult with other NGOs and with BASICS to see about sharing access to technical assistance.

J. Assessment of Counterpart Relationships

The project has collaborated with MOH and the community during all phases of program activities. The Zonal Health Department and the Woreda Health Office have jointly participated with Africare in the proposal design, the baseline survey, the development of the DIP and in the initiation of project services. Support by the Gurage Zone has included assignment of the Zonal Health Department Head, the MCH coordinator, communicable disease control officers and a statistician to work closely with the project.

The Zonal Health Department and Woreda Health Office have provided expert assistance to project staff in the planning and implementation of all training activities, procurement and distribution of drugs and equipment to the health posts, development of the HIS, and hiring of personnel. Additionally, the Woreda health staff has provided coordination and supervisory support to all CHAs/TBAs, health committees, health posts and health station project activities. The MOH seems to have a good relationship with the communities, and has the elements of a system to take on the functions that the project currently fulfills. However, the resource constraints and needs for human resource development make the MOH capacity to take over Africare's role a long-term undertaking.

In addition to the training and supplies provided to the MOH health stations, the project provides per diems according to MOH and NGO policies for MOH staff who are involved in supervision, training, and evaluation activities.

The project has had linkages with a local Catholic hospital in Gurage Zone, Atat Hospital. Practical training for the CHAs/TBAs was conducted at Attat Hospital and in Attat's community health program.

The Regional health office has been kept abreast of project progress through reports and meetings, and the Regional DPPC has been consulted on various project matters.

K. Referral Relationships

The CHAs and TBAs trained under the project were trained by MOH staff, including personnel from the health stations which serve as referral sites for the CHWs. In addition, the CHAs and HAs received practical refresher training which included participation in community health and clinical activities of the Catholic hospital which is the referral site for HSs. This aimed at reinforcing the capacities of the HS staff, as well as strengthening the referral system and linkages between the HS and the referral hospital.

With the exception of Quante Health Post, the CHAs and TBAs seem to see the personnel from their Health Station every month, at least, during EPI activities, which assists in creating linkages and increasing referral and feedback. Numerous TBAs described their referrals to the health stations and generally knew the outcomes of these referrals. Several of the CHAs mentioned that they see the HS personnel about once a week, which allows comparing of notes and sharing information.

As noted, the quality of the health services available at the referral centers (Heath Stations and Attat hospital) vary greatly. A review of register for 40 to 60 of the most recent patient diagnoses and treatments in the four Health Stations visited showed appropriate diagnosis and treatments in 25, 25, 75 and 85% of cases, approximately. As mentioned above, training in this area is planned.

The project is working to increase outreach activities by the HS for EPI, ANC and soon FP, which effectively brings the referral site closer to the community. The trained CHAs and TBAs are able to identify cases needing referral, and know where to refer them. In addition, the health education of communities seems to be increasing the willingness to make the trip to referral sites e.g. to Attat for nutritional rehab, to HSs for high-risk or difficult deliveries, etc.

L. PVO/NGO Networking

The project site was chosen because of the absence of other NGOs in the area. However, there is collaboration with the Catholic hospital and community health project within another woreda of Gurage zone, and with the Irish NGO GOAL, which is running a clinic and health posts in another Gurage woreda. Project zone HAs and CHAs spent a week of practical training at the Catholic hospital, and Goal has been consulted on a number of questions ranging from administrative policies to training protocols.

CRS has recently begun some food distribution and growth monitoring activities in a few project PAs, and an attempt was made to include CRS staff in the mid-term evaluation. This was not successful, but a discussion was held with CRS and ZHO staff to discuss how the two projects' activities will overlap or complement each other.

The Africare project manager participates in regional coordination meetings for NGOs sponsored by the Regional Health Office which enables exchanges of ideas. In addition, the Africare Health Sector Coordinator in Addis participates in meetings and the steering committee of the CRDA, the umbrella development NGO group for the country.

M. Budget Management

The project seems to have spent about half of its budget during the first two years of the project. This is partially due to the reduced expatriate advisor LOE in the first year of the project.

VI. PROJECT SUSTAINABILITY

A. Community Participation

The project has a community-centered approach whereby the CHAs and TBAs are selected by the community from each PA, with assurance from the community to support the workers both monetarily and through provision of a health post. This approach fosters community ownership and participation, enhances sustainability and leads to improved health outcomes.

The women in the focus groups stated in general that the CHAs and TBAs were paid by their community, so they understand that the CHWs are supported by the community and not by Africare. The women stated that they participate in the health and health education activities initiated or carried out by the CHWs, and many had participated in a group hygiene activity.

The recently established or revitalized Health Committees are supposed to ensure political support for community health activities and financial support for the community health workers. The first set of these committees have been established in the project zone PAs for around 8 months and seem to be working fairly well. The Health Committees are very dependent on the personalities of the people involved. During the evaluation some were seen to very dynamic, whereas other Committee members and PA Chairmen seemed less interested or involved.

Several PAs visited were constructing a new health post for CHW activities; most of the CHAs reported receiving financial support from their communities, and most TBAs who were providing delivery services were being compensated either by the individual mother or by the community. Some of the PA chairmen had helped mobilize communities and the health committee to address health issues.

B. Ability of NGOs to Sustain Activities

There are almost no international NGOs active currently in the area who could continue support to Africare-initiated activities. CRS presence in neighboring woredas does not presuppose ability to support the community-based sustainable health activities, as CRS activities currently emphasize food distribution. It is hoped that through further discussions with GOAL and CRS, some consistent approaches can be reached for the PAs within a woreda, to avoid conflicting expectations.

Local NGOs are practically non-existent in the area. It is hoped that the work which is beginning with women's groups will increase their ability to carry out both income-generating and community-mobilizing activities.

C. Ability and Willingness of Counterpart Institutions to Sustain Activities

MINISTRY OF HEALTH

Regional Health Department (RHD):

The RHD seems interested in the community support activities that the project has initiated. However, the RHD's resources are stretched quite thin, both in terms of personnel as well as transport, etc. They seem willing for activities to carry on within the MOH policy, or with small pilot activities. They do not, however, have the capacity to provide the sustained support to community ownership and capacity building that will be needed for the next few years to ensure sustainability of project gains.

Zonal Health Department (ZHD):

The Zonal Health department has several extremely talented staff who are very interested in the community-based activities they have developed with the project. Gumer, however, is only one of 11 woredas in the zone, so although their excellent technical staff is sometimes available for design, training, and evaluations, they do not currently have the transport or time available to refine the strategies begun under the project.

The ZHD staff are very interested in testing CBD of contraceptives and exploring improved methods of growth monitoring and promotion, and continue to be a strong partner.

Woreda Health Department (WHD):

The WHD has a small staff with some management and training ability, but the same kind of resource constraints as noted above. They work closely with the project staff in all aspects of project design, management and monitoring.

A change in the project design was made to strengthen the sustainability of the project activities by removing the HIS Officer position from the project. This position does not fit into the current MOH system. It was determined that sustainability will be strengthened if the Project trains MOH staff in supervision and HIS management. This is being done as on the job training, as well as through formalized training.

The CSP did not want to create new positions within the MOH that would not be maintained once the project has ended, thus it was also originally planned to eliminate the Technical Field Coordinator position. It was, however, considered more important for sustainability to ensure intensive supervision of the CHAs and TBAs, and to ensure good collaboration was created between these CHWs and the PAs and Health Stations and WHO that are supposed to support them.

Overview of Health Center Services: The evaluation team visited four of the five project area health stations to hear their assessment of the project's activities at their level, and in the communities, and the potential for continuation of these activities. These visits also served as a basis for understanding the existing health structure in the area, which was and will be the source of health care and supervision to those villages which have been involved in project health activities. (A case by case description is found in Appendix E.)

The health centers usually have two to three staff members, who provide curative and preventive MCH/family planning care. They all carry out EPI activities, both fixed and outreach. Some health education is done in the clinics, mostly on an ad-hoc basis with individual clients. Certain clinics have a health education program, with specific topics for each day, and assigned to a certain member of the HS team.

Review of registers for appropriate diagnosis and treatment of curative consultations showed a range of 25-85% appropriate diagnosis and treatment. Feedback was given by the MOH staff to each health station and health post worker on the observations made.

WOREDA COUNCIL

The evaluation team met with the head of social sector for the Woreda Council for a feedback session after the evaluation fieldwork. He expressed his interest in increased involvement in community health activities, but again stated that he did not any resources for supervision.

However, his political influence can be used to encourage Health Committees and PA Chairmen to provide support to CHAs and TBAs, and can be used for other community health mobilization needs.

D. Sustainability Plan, Objectives, Steps Taken, Outcomes

Many of the outcome objectives of the project are ones that relate to the continued ability of the health system and communities to offer health education and services at the village level. As described above, the project has strengthened government health services, worked to create a cadre of competent community volunteers, and has continuously negotiated with MOH and PA authorities to provide continued support for implementation, supervision and training for village level activities initiated by the Project.

The sustainability objectives in the proposal were that by the end of the project:

1. Regional, Zonal, Woreda and health institutions staff will be involved in needs assessment, planning, training, service delivery, data collection and analysis, and evaluation in order to help develop skills in these areas so as to enable them to continue to manage MCH/PHC activities in Gurage Zone without Africare technical assistance.

2. Effective strategies and lessons will be documented and shared with regional health authorities.

3. Mechanisms for service delivery and community education will be in place enabling the zonal health department to maintain key maternal health and child survival services such as immunization, antenatal care, treatment for ARI, and family planning services through established health institutions and CHAs and TBAs.

4. Unit recurrent costs will be kept to a minimum so that the local government will be able to continue MCH/PHC program implementation beyond the project period.

5. The role of CHAs and TBAs in local communities will be valued and supported by their communities and sustainable mechanisms will be in place both within the community and on the part of the zonal health department to provide community-based workers the supervision, supplies and motivation they need to continue effective work.

Progress toward these objectives is being monitored as the project carries out its activities, which are all aiming at these objectives. A process leading to greater and then complete assumption of responsibility for project initiated activities by local institutions is ongoing.

The project is doing a very good job of monitoring project activities, but these steps and benchmarks which specifically focus on sustainability issues need to be more clearly laid out. In addition, this should be a primary focus during the third year of project implementation, and a follow-on phase should be almost exclusively focused on sustainability i.e. reinforcing MOH and community capacities to continue and then eventually expand the community health activities initiated under the Africare project.

Possible steps may include: 1) gradual absorption of project staff responsibilities by the zonal health department and woreda health staff; 2) strengthening and establishment of community

health committees responsible for overseeing community efforts to support VHWs and TBAs; 3) creation with the zonal health department of a follow on and then a post-project work plan.

Project staff agreed that reinforcing links with MOH and community authorities will be a priority activity for the rest of the project period, as they have been before. One of the major constraints to continued activities of the CHAs and TBAs is the lack of transport available for supervision. Another major obstacle is the difficulty of ensuring drug supply.

The health centers will continue to carry out their family planning and prenatal care services, serving as a reference center for clients and information source for counselors and TBAs. The health center staff, however, differ in their level of commitment to supervising village volunteer activities, as well as their level of skill.

The following are sustainability goals and objectives elaborated by the team, and their assessment of progress.

GOAL	END OF PROJECT OBJECTIVES	STEPS TAKEN TO DATE	OUTCOMES
-There will be health resource people available in the villages	-A core of trained CHAs and TBAs will have been created in each PA	-Selection and training of 39 CHAs and 31 TBAs in PHC	-39 CHAs and 31 TBAs were trained in PHC; most passed post-test -all CHAs and TBAs received refresher training

-These trained CHAs and TBAs will continue their activities after project end	-Motivation and support coming from or facilitated by the project are taken over by the community	-Supervision and refresher training of actives -Provision of supplies -Encouragement of fees and support from community	-About 34 of the 39 CHAs trained are active. -CHAs and TBAs meet monthly with their Health Station -Meetings held regularly with PA chairman and Health Committee in 39 PAs -About 3/4 villages provide some support to CHAs; most TBAs providing services receive fees or support -Discussions begun with MOH for CHA and TBA resupply
-Existing institutions will support activities of CHAs and TBAs	-Creation of working linkages between CHAs, health station staff and PA Chairmen and Health Committees	-Discussions and collaborative activities with institutions -Creation of end-of-project plan	-CHAs from most PAs already organize their own meetings with HS staff and Health Committees

VII. LESSONS LEARNED/RECOMMENDATIONS

A. Project Design

1. Integrated projects, including water and income-generating activities, are more effective in improving health because they are better able to generate interest, and enable women to take action to address the causes of ill health and malnutrition. In this project, some strongly felt needs are not being met, (e.g. water, IGA, food security) making true community commitment and involvement less feasible. **Fiid creative**

sources for funding of water and income-generating activities in the PAs, since these are top priority and are essential for improved health.

2. Short-term projects are too short for long-term results to be measurable, so they tend to focus on short-term measurable results. A **follow-on project of at least two years is recommended, and future projects in other woredas should be funded on a minimum four year cycle.**
3. Men's agreement to the use of family planning and **AIDS** prevention methods is essential, but they also play a very important role in health-related behaviors such as hygiene and nutrition of children, and in health care-seeking decision making. The evaluation showed men's interest in being more informed and involved in health matters. **Men should be included in future design and implementation phases as full actors, and interventions should be specifically targeted at the roles men play.**
4. The project advisor could play an important role in strengthening the ZHO. The **advisor, working in close collaboration with the ZHO, should identify institutional needs, and help transfer lessons from the Gumer woreda to others, while identifying and addressing zone-wide or regional constraints to PHC implementation.**
5. **The Project should be extended for a second phase and expanded into a second woreda, emphasizing lessons learned and consolidation of community support and management, and MOH supervision and supply, of community health agents.**

B. Project Implementation-Technical

1. The CHWs' levels of motivation and capacity vary somewhat, as do, more markedly, the levels of community support, dynamism and organization in the different Pas. **Special effort needs to be made to work with those PAs who were the most disadvantaged or least organized. In the case of serious, irreconcilable problems or default, however, the PA should be dropped.**
2. **The selection process for CHA and TBA candidates should include the HS staff more, and inappropriate candidates who arrive for training should be refused admittance.**
3. It is sometimes difficult for mothers to apply knowledge obtained, due to lack of services or commodities. **Efforts should be made to avoid creating demands that are impossible to fill, given available government health services or economic realities.**

4. **Follow-up should be done on the agreement made during the evaluation that CBD could start in the HPs. Profits from sales of contraceptives would provide an important incentive to CHWs.**
5. CRS reported that their lending schemes for women in Ethiopia have had a > 95 % return rate. The existence of successful development committees and management committees for maintenance of water supplies in other Woredas leads the team to believe that credit or IGA schemes for nutritional improvement would be successful. **Credit/IGA activities should be started as soon as possible with the women's groups who have been working with Africare.**
6. Re-evaluate the use of posters as health education materials in this mostly non-literate **area,** and **focus EC activities on more interactive, traditional and entertaining forms of education and discussion.**
7. **More emphasis needs to be placed on the actions to be taken in case of growth faltering, and the results, if any, of these actions.** If this step is not followed through, the growth monitoring has no impact on malnutrition.
8. **Service providers' own beliefs and fears regarding FP should be addressed during future training courses and supervisions to ensure that they are transmitting appropriate attitudes as well as messages.** In addition, the under five mortality rates must be not only dropping but perceived as such before families are willing to forgo having large families,
9. Full-time presence in Welkite and in the Gumer Woreda by the Project Advisor is essential in order for the Project Manager to be more able to carry out coordination with the WHO and increase joint field supervision of health posts. **The project advisor should spend at least 6 nights a month in the Gumer woreda, in addition to full-time presence in Gurage Zone.**
10. **Additional technical assistance should be obtained in IEC and use of HIS for project orientation.**

C. Project Implementation-Administrative

1. Participatory staff meetings and respect by the senior staff of project personnel's contributions helps project morale. However, the turnover in senior staff (Country Representative, Country Health Sector Advisor, Project Advisor, and the protracted absences or stays in Addis by the new Project Advisor) created a certain lack of continuity and clear administrative and managerial expectations. ***Expectations regarding work performance, place of work, and resource management should be more***

clearly established and clarified for all staff. Clear directives should be established in these matters, with clearly outlined consequences in case these conditions are not met.

2. Project activities were extremely well-documented. This ensures clarity for historical purposes, but the overall picture was sometimes lost in the details. **Keep an overall chart of population figures, objectives, progress indicators, priorities.**
3. The project HIS lost focus as the indicators were updated and the HIS was not adapted, as well as because analysis and resulting action has been **weak. Use HIS to focus training and supervision. Clarify and establish a finalized list of objectives.**

D. Project Sustainability

1. Helping health station personnel see "what's in it for them" in working with the CHWs increased their willingness to spend time training and supervising, and increased the validation of CHWs. **Increase the role of the public health workers who are responsible for the supervision of project-initiated activities in the process of choosing and installing local health volunteers in the villages in their catchment area to increase appropriateness and ownership.**
2. The non-monetary benefits received by CHWs such as technical training and supervisory visits were very important in creating motivation, an ***esprit de*** corps, and validating the CHWs. **Involve communities in needs identification, data gathering, problem-solving, evaluation and feed-back. This involvement is essential especially to validate and support the work of community volunteers.**
3. **During the remaining months of the project, staff should focus on reinforcing CHA skills. More time should be invested in follow-up of problems of drug and other supplies for the CHWs, as well as strengthening community/PA support for CHWs.**
4. **Special effort must now be made to strengthen linkages with MOH and other institutions, in order to transfer oversight of project-initiated activities.**
5. **Health center staff should ensure continuous supervision of CHAS and TBAs to update their knowledge, especially for TBAs, since most are illiterate and have difficulty remembering new information.**
6. **A dosage sheet for non-literate workers should be developed.**

VIII. SUMMARY

APPENDICES

APPENDIX A:

MEMBERS OF THE EVALUATION TEAM

TEAM LEADER
Waverly Rennie, MPH, independent consultant

AFRICARE
Stephan Solat, MPH, Health Program Manager, Washington
Ato Haile Wubneh, Health Sector Advisor, Addis Ababa
Blaine Pope, Country Representative, Addis Ababa

MINISTRY OF HEALTH
Solomon Mengiste, MD, MPH Technical Expert, Community Health, Gurage ZHO
Ato Kinfe, Woreda Health Officer, Gumer WHO
Health Assistant, Mugo Health Station
Health Assistant, Bole Health Station
Health Assistant, Arekit Health Station
Health Assistant, Zizencho Health Station

AFRICARE/Welkite
Solomon Tesfaye, MD, MPH, Project Manager
Sirkalem, RN, Field Coordinator
Genet Kore, Project Accountant

APPENDIX B:

Project Area Map
Hard copy enclosed

APPENDIX C: **Project Timeline**

In Solomon's file in 6.1

APPENDIX D:

OCTOBER 1996 MIDTERM EVALUATION SCHEDULE FOR GURAGE CHILD SURVIVAL PROJECT

AFRICARE/ETHIOPIA

Monday	Tuesday	Wednesday	Thursday	Friday
	1 ADDIS WR arrive PM	2 ADDIS Briefing Africare, US AID	3 TO WELKITE Meet with Africare team, ZHO	4 TO AREKIT Eval team planning meeting
7 WELKITE Design QAs Discuss project strategy	8 WELKITE Revise QAs Logistics	9 TO GUMER Kebul PA Mugo HS	10 GUMER Silase PA Cherona Gemezager PA	11 GUMER Kebul EPI Derbona Senen PA Bole HS
14 GUMER Gugeso PA Arekit HS	15 GUMER Arekit Shelko PA Zizencho PA Zizencho HS	16 GUMER Quante PA Feedback to Woreda Council	17 WELKITE Synthesis	18 TO AWASSA Feedback to RHO, DPPC, BASICS
21 ADDIS Synthesis, writing	22 ADDIS Feedback USAID WR leaves PM	23	24	25

Arekit HS: Arekit Shelko PA

Mugo HS: Kebul, Silase, and Cherona PAs

Bole HS: Derbona and Gugeso PAs

Zizencho HS: Quante and Zizencho PAs

APPENDIX E:

Qualitative Interview and Observation Guides

GUIDE FOR INTERVIEW OF PA CHAIRMAN AND HEALTH COMMITTEE MEMBER

1. Africare is working with the Ministry of Health in your PA to increase availability of health services through CHAs and TBAs. How have you been involved in these MOH community health activities?

2. Is there a Health Committee, and is it functioning? (Was it functioning before Africare activities?)

3. What is the role of the PA and the health committee in improving the health of the community? (Probe: How often does the Health Committee meet? When did you meet last, and what was on the agenda?)

4. Which Health Posts have you visited?

5. What is the role of the CHAs and the TBAs? Do you think they are sufficiently covering the PA? Do you think one CHA can cover the whole PA?

6. What contact have you had with the Africare and MOH staff who work with the CHAs and TBAs? (List: Woreda Health Officer, Health Station staff, Africare Project Advisor, Africare Project Manager, Africare Field Supervisor)

7. Do you think malnutrition is a big problem in your community? What role can the PA/Health Committee play in following up on/assisting children who are not growing adequately?

8. Do you think the services provided to the community by the CHA and the trained TBAs are valuable? What support are they receiving from the PA, the Health Committee, the community? Do you think the PA, the Health Committee and the community will continue to find a way to support them in their activities?

GUIDE FOR MOTHERS OF CHILDREN O-5: FOCUS GROUP DISCUSSION

1. Where do you go when you or your child are sick? What type of services do you use? (e.g. antenatal care)

2. What do the CHA and the trained TBA do in your community? (Most important/useful? What services are not being provided that should be?) How are the CHAs and TBAs compensated for their services?

3. What have you learned from health education talks?
   - about diarrhea?
   - about children's nutrition?
   - about breastfeeding?
   - about family planning?
   - about what a pregnant woman should do for her health?

4. What are the obstacles to applying the information you learned? to using immunization services? an tenatal care?

5. Would you like men to receive health education talks about certain themes? Would you like to have health education talks in groups for women separately from men, or would you like mixed groups? What about for family planning?

6. What do you see in this poster? What message do you get from it? How else could we convey this message, or make this better?

7. Do you think there has been a change in your village because of the activities of the CHAs and TBAs?

HEALTH STATION INTERVIEW

1. What kind of activities are you doing today?

2. Number of health assistants _____

3. Number of PAs served by the HS _____

4. Number of CHAs trained under the HS _____
   Number still functioning_____ (received drugs, working in HP, reporting)

5. Number of TBAs trained under the HS _____
   Number still functioning _____ (received kit, working in HP, doing deliveries, reporting)

6. Are the CHAs able to adequately cover their catchment area?

7. What support have you received from Africare for the following interventions?
   EPI_____
   GM/P_____
   CDD_____
   ANC_____
   FP_____
   Health Education _____

8. Has Africare support helped you increase the amount or effectiveness of outreach you do?

9. How could the IEC materials which the project has provided be improved, or what kinds would be more useful?

10. How is your relationship with the CHAs and TBAs?
-supervision (technical and administrative)
-reporting
-meetings

11. What is your relationship with the PAs and their Health Committees?

12. What has been your relationship with the Africare and MOH staff?
Zonal Health Office staff
Woreda Health Office staff
Africare Project Advisor
Africare Project Manager
Africare Field Supervisor

HEALTH STATION FACILITIES OBSERVATION GUIDE

REGISTER:
compare August EPI register to August EPI report

review of 2 pages of register for adequate/inadequate treatment (# A/I)

WALKABOUT:
Is cold chain operating adequately? (refrigerator, cool box, stock of vaccines and syringes)
When was the last breakdown (equipment, supplies, vaccines?)

Drug stock management system-
-is there a drug store?
-is there a drug stock register in and out? or another form of supply management?
-how many drugs are currently out of stock?

Is there any information posted about health station hours?

Is there any information posted about fee schedules?

-Supplies from Africare in place

Item	Y	N
Bookshelf		
2 shelf for drug storage		
2 benches		
1 stethoscope		
1 sphygmomanometer		
1 horse!		
1 delivery couch		
1 examination bed		
1 medical screen		
1 IV stand		
At least 2 of the 4 posters		
1 loudspeaker		
registration book for drugs		
registration book for patient info		

HEALTH EDUCATION TALK OBSERVATION GUIDE

ACTION	very good	good	insufficient
announces subject of health education talk			
uses teaching aids, song, story, demonstration			
pace is appropriate			
appropriate number of subjects/messages			

appropriate language/terminology			
asks mothers to repeat the essential messages			
makes final, simple synthesis of take home message			
asks mothers if they have questions/interactive			
content is accurate			

COMMENTS:

GROWTH MONITORING OBSERVATION CHECKLIST	VG	G	I
Scale is zeroed			
Child is appropriately dressed			

Can read the weight within 200 grams			
Can register the weight (write weight, date)			
Can plot the weight on the growth chart			
Can analyze the weight in relation to the previous weight			
Does analyze the weight in relation to the previous weight			
Communicates the growth status to the mother (growing well, not growing, growth dropping)			
Gives appropriate education and advice			
Gives encouragement to mother, treats with respect			
Asks mothers if she has questions			
Asks mother to repeat instructions			

EXIT INTERVIEW GUIDE FOR MOTHERS OF CHILDREN WEIGHED

1. Your child was just weighed. What information did the health agent give to you?

2. If nutritional advice was given, how will you be able to apply this advice at home? Did they make an appointment for you to return, or to visit you?

CHA INTERVIEW

What activities are performed at the **health** post?

What are the things that you have learned that are the most useful?

What changes in behavior have you seen in the villagers due to the new knowledge and health activities that you do?

Are you doing growth monitoring? Why do you do it? What do you do if you find a child who is not growing well?

What techniques do you use to counsel mothers about family planning?

How do you assess and treat children with diarrhea? What do you tell mothers of children with diarrhea?

What IEC materials or techniques do you use? What are the strong and weak points of these materials?

Do you make home visits? What do you look for on these visits?

How many hours a week do you spend on your activities as a CHA?

What is your relationship with the TBA?

What is your relationship with the PA and the Health Committee?

What kind of support have you received from the community or from the PA since you began carrying out CHA activities?

What is your relationship with the Health Station? the Woreda Office?

What is your relationship with Africare staff-
project advisor
project manager
field supervisor

Problems/suggestions

HEALTH POST OBSERVATION GUIDE

Observe stock of drugs, observe equipment
Review register
Observe health education talk: Observation Guide
Observe growth monitoring session: Observation Guide

TBA INTERVIEW AND OBSERVATION

Number of deliveries attended before the TBA training: _____

Number of deliveries attended since the TBA training:
_____normal
_____complicated

How were you selected?

Do you want to continue to work as a TBA?

How many pregnant mothers do you see every month? _____

Number of mothers referred for antenatal care or high risk delivery since your training _____

What do you do when you attend a delivery?

What messages do you give to mothers during:
-pregnancy?
-labor and delivery?
-postnatal care?

May we see the supplies you received after your training? Any IEC materials?

Are they enough to attend deliveries?

What is your relationship with the CHA?/HS? (To whom do you report, how, and how often?)

What community support do you receive- either monthly or per delivery?

Problems/solutions